Authorization to Release/Request Patient Information To:
New England OB/GYN Associates, Inc.

617-731-3400/fax 617-566-2224

Patient Name _____ DOB _____

Address _____ City _____

State _____ Zip _____ Phone _____

I authorize the following facility:_____
to disclose and deliver information from my medical record to:

New England Ob/GYN Associates, Inc
200 Boylston Street, Suite 301
Chestnut Hill, MA 02467

Fax: 617.566.2224

NEOGA Physician _____

I understand that treatment and coverage is not based upon my signing this authorization.

- I understand that this authorization is subject to revocation at any time unless action based on it has already begun. This authorization expires in six months from the date of signature.
- I understand that the information may be subject to re-disclosure and may no longer be protected by federal or state law.
- I further release the persons and/or agencies named above from any liability arising from the release of this information to such persons and/or agencies, provided the said release is done substantially in accordance with applicable law.

I understand that the information in my health record may include information relating to sexually transmitted disease (STD), acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment of alcohol or drug abuse.

If the following sensitive information applies to you, please indicate if you would like this information released/obtained (include dates where appropriate):

HIV Testing and Results □ Yes □ No Dates: _____
STD Results (other than HIV) □ Yes □ No Dates: _____
Genetic Testing □ Yes □ No Dates: _____
Mental Health (other than psychotherapy notes) □ Yes □ No Dates: _____
Alcohol, Drug, or Substance Abuse Records □ Yes □ No Dates: _____

□ I DO □ I DO NOT agree that a copy of this form is valid as the original.

⇒ **SIGNATURE** _____ Date _____

⇒ _____

Witness or parent/guardian signature if applicable Date

Comments: